STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	04/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of complaint IN00088259 Complaint IN00088259 Unsubstantiated due to lack of evidence. Survey dates: April 25, 26, 27, 28, 29, 2011 Facility number: 000059 Provider number: 155697 AIM number: 100266560 Survey team: Avona Connell, RN TC Donna Groan, RN April 25, 26, 28, 29, 2011 Gloria Reisert, MSW Census bed type: SNF: 09 SNF/NF: 66 Total: 75 Census payor type: Medicare: 14 Medicaid: 51 Other: 10 Total: 75	F0000	Kim Rhoades, DirectorLong Term Care2 North Meridian StreetIndianapolis, IN 46204 Re: Survey Event ID EJQX11 Annual and Complaint Survey Dear Kim Rhoades, Please find enclosed the plan of correction for Clark Rehabilitation and Skilled Nursing Center's Complaint Survey that took place on April 25, 2011 through April 29, 2011. Please accept this POC as our letter of credible allegation and a request for desk review on or after May 27, 2011.Please feel free to contact me if you have any questions concerning the enclosed at (812) 282-8406. Respectfully, Mary Josephine Ann Fenol, HFAClark Rehabilitation & Skilled Nursing Center517 North Hallmark BlvdClarksville, IN 47129	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 15 Supplemental sample: 03 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 5-5-11 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the physician when 1 of 3 residents reviewed for antibiotics in a sample of 15 residents did not receive the full dose of intravenous (IV) antibiotic (Resident #75) and when 1 of 15 residents reviewed for vital sign monitoring in a sample of 15 residents	F0157	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible	05/27/2011

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	had a blood pressure reading that fell below physician-set parameters. (Resident #48) and when ordered ear drops were not provided for 1 of 1 resident reviewed with an order for ear drops in a sample of 15. (Resident #8) Findings include: 1. Review of the clinical record for Resident #75 on 4/28/2011 at 8:50 a.m., indicated the resident had diagnoses which included, but were not limited to, paraplegia, history of osteomylitis [infection in the bone] with MRSA [methicillin resistant staphylococcus aurous] decubitus ulcers, and chronic pain syndrome. Based on abnormal lab work on 4/10/2011, the physician ordered IV Levaquin 500 mg [milligrams] QD [every day] times 7. Review of the nursing notes included an entry dated 4/11/2011 at 11:00 p.m. : "...IV fluids started. Pump kept saying occlusion. Couldn't figure out the problem. Tried to run Levaquin. Didn't get all in..." Documentation was lacking of the physician having been notified of the IV being clogged and of being unable to administer the full dose of ordered		allegation and requests a Desk review on or after **May 27, 2011.** F 157 Notify of changes (Injury/Decline/ Room, Etc.) It is the practice of this provider to ensure that the attending physician is notified of changes in condition to include medications unable to be given per orders and changes in vital signs. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Resident #75: MD notified on4/24/11 and new order for oral antibiotic obtained. · The physician for resident #48 was notified on 5/17/11 to relay blood pressure readings and current physical assessment. Orders received. · On 4/26/11, resident #8's physician was notified of Debrox ear solution. New orders were received. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: · The facility recognizes that all residents experiencing a change in condition have the potential to be affected by this practice.	

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	antibiotic. 2. Review of the clinical record for Resident #48 on 4/25/2011 at 2:55 p.m., indicated the resident had diagnoses which included, but were not limited to, cerebral vascular accident (stroke) with recurrent trans ischemic attacks [mini strokes], coronary artery disease, status post myocardial infarct [heart attack], and congestive heart failure. Review of the nursing notes included the following entries: - "3/11/2011 - 8:15 p [p.m.]: Res in bed resting. Very lethargic but responsive to touch & speech, v/s [vital signs] 85/50...Res was covered over head [with] blanket. bp [blood pressure] on readmission was 114/68. MD notified of results. Just advised to monitor bp for about an hour. If gets lower contact MD again. Fam [family] called." - "3/11/2010 - 8:40 p: bp 78/49" Documentation was lacking of the physician having been notified of the blood pressure having dropped lower than the reading at 8:15 p.m. On 4/28/2011 at 1:20 p.m., the DoN presented a copy of the facility's current		· Audits of 24-hour reports and Medication Administration Records have been completed to review changes and appropriate physician notifications. No other residents have been affected. · Licensed nurses were educated on resident change in condition including notifying physician. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: · The facility's policy and procedure was reviewed and no revisions were necessary. · Licensed nurses were in-serviced and will receive reinforcement education on 5/20/11 regarding notification of changes in resident condition. · The DNS/designee will conduct audits of 24-hour reports Monday through Friday excluding holidays and weekends to identify changes in condition and appropriate physician notification. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · A CQI Audit of Change in Condition tool will be utilized weekly x 4 monthly x 2 then quarterly thereafter to monitor for	

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	policy on "Resident Change of Condition". Review of this policy at this time included, but was not limited to, "Policy: It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs. Procedure:...2. Acute Medical Changes: a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation..." During an interview with the Director of Nursing [DoN] on 4/28/2011 at 1:30 p.m., she indicated the physician should have been notified of these issues. During a second interview with the DoN and with the Administrator on 4/29/2011 at 9:20 a.m., they indicated the nursing staff had been inserviced on March 8, 2011 regarding physician notification. 3. On 4/25/11 at 12:25 p.m., in interview with Resident #8, the resident indicated he had wax build up in his ears and hadn't received treatment for it. On 4/26/11 at 8:15 a.m., the clinical		compliance. · MARs will be audited twice weekly x 4 then once weekly x4 then monthy x 2 then quarterly thereafter to monitor for compliance. · Data collected will be submitted to the CQI Committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process. **Compliance date: May 27, 2010.**	

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	record for Resident #8 was reviewed. The resident's diagnoses included, but were not limited to dementia, cerebral vascular accident (stroke), and diabetes mellitus. Physician Telephone Orders included, but were not limited to "4/22/11 6 P Debrox ear solution - use as directed: 2 drops in R (right) ear x 3 days - Rinse R ear canal with warm water after 3rd application of Debrox." Review of the April 2011 Medication Administration Record indicated the medication was to begin on 4/23/11 and end on 4/26/11. The medication had not been initialed as being given. In interview with the Director of Nursing Service on 4/26/11 at 11:55 a.m., she indicated Pharmacy sent the Debrox on 4/22/11 and it had not been opened. The physician had not been notified the ear drops had not been provided. 3.1-5(a)(3) 3.1-5(b)			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to assess 2 of 2 residents with a picc (peripheral inserted central catheter) an intravenous IV line for signs/symptoms of complications when the line had been partially/fully dislodged. (Residents #75 and #48). This deficient practice affected 2 of 15 residents in a sample of 15 residents.	F0272	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after **May 27, 2011.F**	05/27/2011

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	Finding includes: 1. Review of the clinical record for Resident #75 on 4/28/2011 at 8:50 a.m., indicated the resident had diagnoses which included, but were not limited to, paraplegia, history of osteomylitis [infection in the bone] with MRSA [methicillin resistant staphylococcus aurous] decubitus ulcers, and chronic pain syndrome. Review of the nursing notes between 3/1 and 4/26/2011 indicated the following entry: - "4/24/2011 - 3p [p.m.]: Res [resident] was in bed getting IV therapy. She turned on the other side & pulled picc line out. Didn't pull out all of the way. We taped line in place & called MD [physician]. MD stated to call Picc Fusion to get evaluated & replaced. Review of the notes failed to locate documentation of an assessment of the IV site for bleeding, injury or complications, the length of the IV, or whether the tip of the IV was still intact after it was dislodged. 2. Review of the clinical record for Resident #48 on 4/25/2011 at 2:55 p.m.,		**272 Comprehensive Assessments It is the practice of this provider to ensure residents are comprehensively assessed to include assessment of Peripheral Inserted Central Catheters. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · Resident #75 physician notified on 4/24/11 that PICC was pulled. New orders received. PICC Fusion evaluated on 4/25/11. · The physician for resident #48 was notified on 5/17/11 and order received. · Resident #48 completed antibiotic therapy with oral medication. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken · Residents with peripherally inserted central catheters have the potential to be affected and were identified. · Appropriate physicians were notified and orders were received to measure PICC lines daily. · Medication Administration Records were updated to include these new orders. · Clinical records were reviewed to ensure PICC length was available. Institutions placing line were contacting for PICC**	

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	indicated the resident had diagnoses which included, but were not limited to, cerebral vascular accident (stroke) with recurrent trans ischemic attacks [mini strokes], coronary artery disease, status post myocardial infarct [heart attack], and congestive heart failure. Review of the nursing notes between 3/1 and 4/26/2011 indicated the following entry: - "3/13/2011 - 9p [p.m.]: Res. pulled out picc line to LUE [left upper extremity]. Bleeding stopped [without] pressure being applied. Site now covered..." Review of the notes failed to locate documentation of an assessment of the IV site for injury or complications, the length of the IV, or whether the tip of the IV was still intact after it was dislodged. During an interview with the Director of Nursing on 4/28/2011 at 1:30 p.m., she indicted there should have been some type of an assessment after the IV had been pulled out or dislodged. 3.1-31(c)(2) 3.1-31(c)(6) 3.1-31(c)(13)		**length if not available in clinical record. · The care plans were reviewed and updated by IDT. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur · The facility's policy and procedure was reviewed with no revisions needed. · Licensed nurses will be in-serviced on 5/19/2011 and will receive reinforcement education on 5/20/11 regarding measurements of PICC lines daily and if becomes dislodged. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place · The DNS/designee will complete audits of Medication Administration Records twice weekly for four (4) weeks then weekly for four (4) weeks then monthly for four (4) months to ensure PICC lines are measured daily. · The DNS/designee will audit 24-hour reports daily for dislodged lines to ensure length of line is measured and compared to insertion length. · Data collected will be submitted to the CQI Committee for review and follow up as needed. An action**	

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			plan will be developed as needed for issues identified by the CQI process. Compliance date: May 27, 2011.	
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. A. Based on observation, interview and record review the facility failed to ensure eye drops were administered properly for 1 of 1 resident observed receiving eye drops, during the medication pass, in a supplemental sample of 3 (Resident #15) and failed to instill ear drops as ordered for 1 of 1 resident reviewed for ear drops in a sample of 15 residents. (Resident #8) B. Based on record review and interview, the facility failed to follow a physician's order for pulse monitoring prior to administration of the heart medication. This deficient practice affected 1 of 2 residents in a sample of 15 residents reviewed for vital sign monitoring prior to medication administration in a sample of 15 residents. (Resident #16) Findings include: A. 1. On 4/26/11 at 9:25 a.m., LPN #1 was observed preparing medications for Resident #15. In addition to oral medications LPN #1 pulled out Travatan Z 0.004% solution to instill 1 drop in both	F0282	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after **May 27, 2011.** **F 282 Services by qualified persons/per care plan.** It is the practice of this provider to ensure that services are provided in accordance with resident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · The physician for resident #15 was notified on 5/17/11 regarding administration of eye drops. No new orders were given. · The physician for resident	05/27/2011

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	eyes once daily for glaucoma and Alphagan sol (solution) 0.15% instill 1 drop in both eyes twice daily for glaucoma. After entering the room washing hands and donning gloves, LPN #1 preceded to instill Travatan 1 drop into both eyes. After 1 minute she instilled the Alphagan into both eyes. On 4/28/11 at 1:40 p.m., the Director of Nursing Service (DNS) provided the policy and procedure for "Eye Drop(s). The Procedure included, but was not limited to the following: "13. If additional eye drops are ordered wait 5 minutes between each medication. 14...if the patient is receiving two different medications the nurse will wait five minutes between drops or follow the physician orders." In interview with the DNS, at this time, she indicated nursing was to follow the procedure. A. 2. On 4/26/11 at 8:15 a.m., the clinical record for Resident #8 was reviewed. The resident diagnoses included, but were not limited to Dementia, Cerebral Vascular Accident, and Diabetes Mellitus. Physician Telephone Orders included, but were not limited to "4/22/11 6 P Debrox ear solution - use as directed: 2 drops in R (right) ear x 3 days - Rinse R ear canal		#8 was notified on 4/26/11 regarding eardrops and new orders were obtained. The resident has refused to have eardrops applied. Family and physician are aware. · Licensed nurses were in-serviced on 4/26/11 regarding procedure for administration of eye drops. · The physician of resident #16 was notified on 5/17/11 regarding pulse rate prior to administration of heart medication. No new orders were received. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken · The facility recognizes residents receiving eye/ear drops and Digoxin have the potential to be affected. · An audit was completed and residents identified. Medication Administration Records were reviewed to ensure documentation of pre-administration pulse rates was documented. · Licensed nurses were in-serviced on will be inserviced on 5/20/11 on procedure for administration of eye/ear drop and the assessment of heart rate prior to administration of cardiac medications.	

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	with warm water after 3rd application of Debrox." Review of the April 2011 Medication Administration Record indicated the medication was to begin on 4/23/11 and end on 4/26/11. The medication had not been initialed as being given. In interview with the Director of Nursing Service on 4/26/11 at 11:55 a.m., she indicated Pharmacy sent the Debrox on 4/22/11 and it had not been opened. She spoke with the nurses and the medication had not been given.		· The care plans were reviewed and updated by IDT. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur · The facility's policies and procedures were reviewed with no revision necessary. · Licensed nurses will receive reinforcement education on 5/20/11 regarding proper administrator of eye/ear drops and assessment of heart rate prior to administration of cardiac medications. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place · A CQI Audit of MARs tool will be utilized weekly x 4 monthly x 2 then quarterly thereafter to monitor for compliance of documentation of pulses prior to administration of Digoxin. · The DNS/Designee will complete random weekly medication pass observations for weekly x 4 monthly x 5 then quarterly thereafter to monitor for eye and ear drop administration compliance.	

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CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129

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	B. Review of the clinical record for Resident #16 on 4/27/2011 at 8:35 a.m., indicated the resident had diagnoses which included, but were not limited to, severe aortic stenosis, history of congestive heart failure secondary to valvular heart disease, chronic atrial fibrillation, hypertension, and ischemic cardiomyopathy. Review of the March and April 2011 Medication Administration Records (MARs) indicated the resident had an order for Digoxin (a heart medication) 0.125 mg - take 1 tablet by mouth once a day - hold for HR [heart rate] , [less than] 60 dated 10/21/2010. The medication had been administered on the following days despite the pulse not being taken: - March - 3/2, 3/3, 3/11, 3/12, 3/13, 3/14, 3/15, 3/16, 3/17, 3/22, 3/25 - April - 4/8, 4/9, 4/10, 4/19, 4/20, 4/23, 4/24, 4/25		· Data collected will be submitted to the CQI Committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process. Compliance date: May 27, 2011	

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	During an interview with LPN #1 on 4/28/2011 at 11:00 a.m., she indicated the pulse would be documented right on the MAR under the nurse's initial of the medication being given. 3.1-35(g)(2)			
F0387 SS=D	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on record review and interview, the facility failed to ensure physician visits occurred at least every 30 days for the first 90 days after admission and at least once every 60 days thereafter for 1 of 15 sampled residents reviewed for timely physician visits and 1 of 1 resident in a supplemental sample of 2.(Residents #76, 78) This had the potential to affect 16 current residents identified under the care of Physician #1. Findings include:	F0387	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after May 27, 2011. **F 387 Frequency and timeliness of physician visits.**	05/27/2011

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	1. The clinical record for Resident #76 was reviewed on 4/28/11 at 8:50 a.m. The resident's diagnoses included, but were not limited to coronary artery disease, diabetes mellitus and peripheral vascular disease. Resident #76 was admitted to the facility on 11/5/10. A Physician visit was lacking for December 2010, January 2011, February 2011 and April 2011. 2. The clinical record for Resident #78 was reviewed on 4/28/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to Lung Cancer and Atrial Fibrillation (rapid heart beat). Resident #78 was admitted to the facility on 10/5/10. A Physician visit was lacking for December 2010, January 2011, and March 2011. In interview on 4/28/11 at 12:15 p.m. with the staff person in charge of Medical Records, provided a list of 16 current residents under the care of Physician #1. At this time, she could not provided any additional Progress Notes for residents #76 and 78. She indicated there has been a concern with this physician being late for visits. On 4/28/11 at 2:55 p.m., in interview with the Executive Director, she indicated she had spoken with Physician #1 related to timely visits.		It is the practice of this provider to ensure that each resident is seen by a physician at least every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · The physician for resident #76 was contacted for needed visit. The resident was discharged. · The physician for resident #78 was contacted for needed visit. The resident was discharged. · The physician for both discharged residents have been updated on the facility practice of each resident is to be seen by a physician at least every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: · The facility recognizes that all residents have the potential to be affected by this practice. · The Medical Records Director completed full facility audit for timely physician visits. No other	

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	3.1-22(d)(1) 3.1-22(d)(2)		residents were affected. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: · The Medical Records Director will monitor physician visits per policy. · The Medical Records Director will notify physicians via fax prior to date resident is due to be seen. · The physician will be phoned one (1) week prior to date needed to be seen by Medical Records/designee. · The Medical Records Director will notify the Executive Director if any physicians have delinquent visits. · The ED will phone the physician regarding the delinquent visit. · The facility's medical director will be notified and will follow up with physician as needed and visit resident if attending physician has not come in as requested. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · A CQI Audit of residents' physicians visits by the medical records director will be completed weekly x4 then monthly x 5 and	

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			quarterly thereafter to monitor for compliance. · Data collected will be submitted to the CQI Committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process. **Compliance date: May 27, 2011**	
F0499 SS=D	The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on record review and interview, the facility failed to ensure 1 of 35 Certified Nursing Assistants [CNAs] reviewed for current certifications in a sample of 35 CNAs had maintained a current certification (CNA #1) Findings include: Review of employee files on 04/29/2011 at 7:30 a.m., indicated the facility had 35 CNAs. During the review of the CNAs' certifications, it was observed CNA #1's certification had expired on 3/17/2011. Review of the CNA "as-worked" schedule (time card) presented by the Administrator on 04/29/11 at 10:35 a.m., indicated CNA #1 worked between 3/17/2011 and	F0499	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after **May 27, 2011.** **F 499 Employ qualified FT/PT/Consult professionals.** It is the practice of this provider to ensure that professional staff must be licensed, certified, or registered in accordance with applicable State Laws.	04/29/2011

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	4/28/2011 although her certification was not current. During an interview with the Administrator on 4/29/2011 at 10:35 a.m., she indicated CNA #1 did not have a current CNA certificate and did work after the date her certification expired. 3.1-14(s)		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · C.N.A. #1 completed re-certification on 4/29/11. · C.N.A. #1 became currently active on 4/29/11. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: · The facility recognizes that all residents have the potential to be affected by this practice. · The Director of Nursing completed an audit of professional staff on 4/29/11 for current licenses, certifications, and registers. All professional staff was current and active in status. No other residents were affected. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: · The DNS/ADNS/designee will complete audits monthly of licensed, certified and registered professional staff to ensure active and current.	

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			· Staff will be notified prior to expiration of need for re-certification. · Any professional staff without current status will be removed from schedule until active status validated. · Findings will be reported to Continuous Quality Insurance Committee monthly for review and recommendations. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · The DNS/ADNS/designee will conduct 100% audits monthly for six (6) months for current active status of professional staff. · Data collected will be submitted to the CQI Committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process. Compliance date: April 29, 2011	
F9999	3.1-14 PERSONNEL (t)(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers	F9999	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered	05/27/2011

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	who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule not met as evidenced by: Based on record review and interview, the facility failed to ensure a complete health record was obtained for 1 of 5 employee files reviewed. (Housekeeping employee #1) Findings include: Review of employee files on 04/29/11 between 7:30 a.m. and 8:30 a.m. the following was noted. Housekeeping employee #1, with start date of 03/15/11, lacked documentation of screening for tuberculosis. At 10:30 a.m. on 04/29/11, the Administrator provided a copy of a "Annual TB Screening" dated 04/29/11, from Occupational Medicine Physicians. The screening indicated the following: " (name of employee) was evaluated in our		the letter of credible allegation and requests a Desk review on or after May 27, 2011. **F9999 Personnel** It is the practice of this provider to ensure that all personnel have complete health records including screening for tuberculosis. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Housekeeping employee #1 had chest X-Ray completed on 4-19-11 showing the ability to complete duties indicating no active disease. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: · The facility recognizes that all residents have the potential to be affected by this practice. · The ADNS will complete audit of all current employees to ensure up to date tuberculosis screening has been completed. What measures will be put into place or what systemic changes you will make to ensure that the deficient	

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	clinic for his/her annual TB Screening. The Chest X-ray indicated no active disease. These films will also be read by Radiology Associates. We will forward a final report when it is available (usually within 5-7 days.) This employee can perform his/her duties." During interview with the Executive Director on 04/29/11 at 12:30 p.m. she indicated the chest xray was done today. Forty-five days elapsed from the employees start date until the facility obtained documentation of tuberculosis screening. 3.1-14(t) 3.1-14(t)(1) 3.1-14(t)(2) 3.1-14(t)(3)		practice does not recur: · The facility policy and procedure was reviewed with no revisions necessary. · All employee files will be audited prior to scheduling general orientation by front office, and department manager. · All new hires will be approved by Executive Director prior to general orientation. · Department managers are responsible for obtaining ED approval to ensure tuberculosis screening completed prior to general facility orientation. · The Assistant Director of Nursing will track and complete all annual screening for tuberculosis. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · The Business Office will conduct 100% audits of employee files monthly for six (6) months for new hires and then quarterly thereafter to ensure screening for tuberculosis is in place prior to start of resident care. · Data collected will be submitted to the CQI Committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process.	

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